# DEPARTMENT OF WORKERS CLAIMS
# REQUEST FOR MANUAL CHANGES
# FORM

_____ requests that the Department of Workers Claims please make a manual
**(Company Name)**

change to the field(s) checked below.

☐ **Date of Injury** (DN31)

☐ **Nature of Injury** (DN 35) Requires a detailed explanation to be faxed or mailed with this form.

☐ **Social Security Number** (DN 42)

List the changes you wish to make in the space provided below. If you require more room, you may use a separate sheet of paper.

| **JURISDICTION CLAIM NUMBER** | **DN #** | **CURRENTLY CONTAINS** | **CHANGE TO** |
|---|---|---|---|

I _____ on this date _____ approve the changes being requested, and
(Signature of Approving Authority) (Date Signed)

have submitted documentation explaining the need for changes to the fields that require said documentation. For confirmation of this change, I can be reached at _____
(e-mail)(phone)

**FORMS NOT SIGNED WILL BE RETURNED FOR SIGNATURE. NO CHANGES WILL BE MADE TO ANY FIELD UNTIL THE SIGNED FORM IS SUBMITTED.**

Please fax this form to: Attn: Coding Section, (502) 696-5096, or mail to:

Department of Workers Claims
Attn: Coding Section
Prevention Park
657 To Be Announced Avenue
Frankfort, KY 40601